Date of Service: MM / DD / YY	CPT/HCPCS Code:	Location of Service: 1=Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient.
Provider Staff ID:	Total Time: HR: MIN:	F/F Time: HR: MIN:

Focus of session.

DSM-IV-TR Diagnosis Code(s): _____ ICD-9 Billing Code(s): _____

Current Condition (include complaints, symptoms, appearance, cognitive capacity, changes from previous visits, potential for harm, precipitators, strengths):

Therapeutic Intervention:

Response to Treatment:

Progress Toward Measurable Goals/Objectives:

Plan of Care (include indicated client plan changes, next steps, referrals given):

Other Information:

Signature/Title/Credential Date Printed Name

Co-Signature/Title/Credential Date Printed Name